MARYLAND MEDICAL ASSISTANCE PROGRAM
EPSDT: AUDIOLOGY SERVICES
(COMAR 10.09.51)
PROCEDURE CODE AND FEE SCHEDULE

FOR ENROLLED AUDIOLOGISTS/HEARING AID DISPENSERS - Provider Type 19 ONLY

July 2008

Maryland Medical Assistance Program COMAR 10.09.51
EPSDTAudiology Procedure Code and Fee Schedule
(for Provider Type 19- Enrolled Audiologists/Hearing Aid Dispensers)
2008

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PROCEDURE CODE	BRIEF DESCRIPTION	MAXIMUM FEE
Audiology Services		
92506	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION AUDITORY PROCESSING AND/OR AURAL REHABILITATION STATUS	N/C
92507	TREATMENT OF SPEECH. LANGUAGE, VOICE COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); INDIVIDUAL	N/C
92508	TREATMENT OF SPEECH. LANGUAGE, VOICE COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER (INCLUDES AURAL REHABILITATION); GROUP, TWO OR MORE INDIVIDUALS	N/C
92551	SCREENING TEST, PURE TONE, AIR ONLY	$ 8.30
92552	PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	$ 19.72
92553	PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE [COMPONENT OF THE ANNUAL ASSESSMENT]	NCASP
92555	SPEECH AUDIOMETRY THRESHOLD; [COMPONENT OF THE ANNUAL ASSESSMENT]	NCASP
92556	SPEECH AUDIOMETRY THRESHOLD; WITH SPEECH RECOGNITION [COMPONENT OF THE ANNUAL ASSESSMENT]	NCASP
92557	COMPREHENSIVE AUDIOMETRY- PURE TONE, AIR AND BONE, AND SPEECH THRESHOLD AND DISCRIMINATION - **ANNUAL AUDIOLOGICAL ASSESSMENT** ***(annual limitation may be waived if medically necessary and appropriate)***	$ 53.72

ANNUAL AUDIOLOGICAL ASSESSMENT MEANS PROCEDURES PERFORMED BY AN AUDIOLOGIST TO EVALUATE AND MONITOR THE STATUS OF THE PERIPHERAL AUDITORY SYSTEM, AUDITORY NERVE, AND CENTRAL AUDITORY SYSTEM, OR TO ESTABLISH THE SITE OF THE AUDITORY DISORDER BY USING PROCEDURES TO QUANTIFY AND QUALIFY HEARING LOSS BY SITE OF LESION, ON THE BASIS OF PERCEPTUAL, PHYSIOLOGICAL, OR ELECTROPHYSIOLOGICAL RESPONSES TO ACOUSTIC STIMULI, AND TO DESCRIBE ANY COMMUNICATIVE DISORDERS.

KEY

*	**REQUIRES PREAUTHORIZATION FOR ALL RECIPIENTS**
**	**REQUIRES PREAUTHORIZATION FOR RECIPIENTS 3 YEARS OLD AND OLDER**
A/C	**ACQUISITION COST TO THE PROVIDER [PROVIDER MUST BILL ACQUISITION COST]**
B/R	**BY REPORT-ATTACH AUDIOLOGY REPORT, AUDIOGRAM, MEDICAL CLEARANCE & INVOICE TO CLAIM**
I/C	**INDIVIDUAL CONSIDERATION**
N/C	**NOT COVERED FOR PROVIDER TYPE 19 PROVIDERS**
NCASP	**NOT COVERED AS A SEPARATE PROCEDUR**

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92559	AUDIOMETRIC TESTING OF GROUPS	N/C
92560	BEKESY AUDIOMETRY; SCREENING	N/C
92561	BEKESY AUDIOMETRY; DIAGNOSTIC	N/C
92562	LOUDNESS BALANCE TEST, ALTERNATE BINAURAL OR MONAURAL	N/C
92563	TONE DECAY TEST	N/C
92564	SHORT INCREMENT SENSITIVITY INDEX (SISI)	N/C
92565	STENGER TEST, PURE TONE	N/C
92567	TYPANOMETRY (IMPEDANCE TESTING)	$ 22.68
92568	ACOUSTIC REFLEX TESTING; threshold	$ 17.21
92569	ACOUSTIC REFLEX TESTING; decay	$ 18.25
92571	FILTERED SPEECH TEST	N/C
92572	STAGGERED SPONDAIC WORD TEST	N/C
92573	LOMBARD TEST	N/C
92575	SENSORINEURAL ACUITY LEVEL TEST	N/C
92576	SYNTHETIC SENTENCE IDENTIFICATION TEST	N/C
92577	STENGER TEST, SPEECH	N/C
92579	VISUAL REINFORCEMENT AUDIOMETRY (VRA)	N/C
92582	CONDITIONING PLAY AUDIOMETRY	N/C
92583	SELECT PICTURE AUDIOMETRY	N/C
92584	ELECTROCOCHLEOGRAPHY	N/C

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92585	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY (ABR) COMPREHENSIVE	$140.00
92586	AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY (ABR)-LIMITED	$72.16
92587	EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCTS)	$50.00
92588	EVOKED OTOACOUSTIC EMISSIONS; COMPREHENSIVE (COMPARISON OF TRANSIENT AND/OR DISTORTION PRODUCT OTOACOUSTIC EMISSIONS AT MULTIPLE LEVELS AND FREQUENCIES)	$75.00
92596	EAR PROTECTOR ATTENUATION MEASUREMENTS	N/C
92597	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHETIC OR AUGMENTATIVE/ALTERNATIVE COMMUNICATION DEVICE TO SUPPLEMENT ORAL SPEECH	N/C
92598	MODIFICATION OF VOICE PROSTHETIC OR AUGMENTATIVE/ ALTERNATIVE COMMUNICATION DEVICE TO SUPPLEMENT ORAL SPEECH	N/C
92601	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, PATIENT UNDER 7 YEARS OF AGE; WITH PROGRAMMING	$ 149.01
92602	SUBSEQUENT REPROGRAMMING (DO NOT REPORT 92602 IN ADDITION TO 92601)	$ 102.20
92603	DIAGNOSTIC ANALYSIS OF COCHLEAR IMPLANT, AGE 7 YRS OR OLDER, WITH PROGRAMMING	$ 115.51
92604	SUBSEQUENT REPROGRAMMING **(DO NOT REPORT 92604 IN ADDITION TO 92603)**	$ 69.34

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PROCEDURE CODE	BRIEF DESCRIPTION	MAXIMUM FEE
92605	EVAL. FOR PRESCRIPTION OF NON-SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE	N/C
92606	THERAPEUTIC SERVICE(S) FOR THE USE OF NON-SPEECH-GENER - ATING DEVICE, INCLUDING PROGRAMMING AND MODIFICATION	N/C
92607	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; FIRST HOUR (FOR EVALUATION FOR PRESCRIPTION OF A NON-SPEECH-GENERATIVE DEVISE, USE 92605)	N/C
92608	EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (USE 92608 IN CONJUNCTION WITH 92607)	N/C
92609	THERAPEUTIC SERVICES FOR THE USE OF SPEECH-GENERATING DEVICE INCLUDING PROGRAMMING AND MODIFICATION (FOR THERAPEUTIC SERVICES(S) FOR THE USE OF A NON-SPEECH-GENERATING DEVICE, USE 92606)	N/C
92620	EVALUATION OF CENTRAL AUDITORY FUNCTION, WITH REPORT; INITIAL 60 MINUTES	$51.08*
92621	EVALUATION OF CENTRAL AUDITORY FUNCTION-EACH ADDITIONAL 15 MINUTES	N/C
92626	EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR	N/C
92627	EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	N/C
92630	AUDITORY REHABILITATION; PRE-LINGUAL HEARING LOSS	N/C
92633	POST-LINGUAL HEARING LOSS	N/C
V5299	HEARING SERVICE, MISCELLANEOUS (Procedure not listed; service not typically covered, request for consideration. Documentation demonstrating medical necessity required– to be submitted with preauthorization request.)	I/C*

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HEARING AID AND COCHLEAR IMPLANT CODES		
92590	HEARING AID EXAMINATION AND SELECTION; MONAURAL	$78.00
92591	HEARING AID EXAMINATION AND SELECTION; BINAURAL	$78.00
92592	HEARING AID CHECK; MONAURAL	$42.00
92593	HEARING AID CHECK, BINAURAL	$42.00

[92592/92593 – Professional fee for handling repaired aids. Use in place of handling fee- X0117. Also, use these codes when hearing aid (s) is not directly dispensed to the recipient. Codes require visual inspection and listening check for repaired and new aids prior to returning to ordering audiologist.]

92594	ELECTROACOUSTIC EVALUATION FOR HEARING AID; MONAURAL	N/C
92595	ELECTROACOUSTIC EVALUATION FOR HEARING AID; BINAURAL	N/C
V5011	FITTING/ORIENTATION CHECKING OF HEARING AID [SERVICE IS PART OF DISPENSING FEE]	N/C
L8614	COCHLEAR DEVICE/SYSTEM [LIMITED EXTERNAL REPLACEMENT COMPONENTS]	B/R
L8615	COCHLEAR IMPLANT HEADSET/HEADPIECE, REPLACEMENT	A/C
L8616	COCHLEAR IMPLANT MICROPHONE, REPLACEMENT	A/C
L8617	COCHLEAR IMPLANT TRANSMITTING COIL, REPLACEMENT	A/C
L8618	COCHLEAR IMPLANT TRANSMITTER CABLE, REPLACEMENT	A/C
L8619	COCHLEAR IMPLANT EXTERNAL SPEECH PROCESSOR [LIMITED TO NON-REPAIRABLE OUT OF WARRANTY CASES]	A/C*

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PROCEDURE CODE	BRIEF DESCRIPTION	MAXIMUM FEE
L8621	COCHLEAR IMPLANT, BATTERY, ZINC AIR, REPLACEMENT	1.56
L8622	COCHLEAR IMPLANT, BATTERY, ALKALINE, REPLACEMENT	1.56
L8623	COCHLEAR IMPLANT SPEECH PROCESSOR LITHIUM ION BATTERY, A/C (REPLACEMENT)	
L8624	COCHLEAR IMPLANT SPEECH PROCESSOR LITHIUM ION BATTERY, A/C EAR, (REPLACEMENT)	

***Hearing Aids** – medically necessary and effective new aids that are recommended and fitted by an audiologist in conjunction with written medical clearance from a physician who has performed a medical examination within 6 months – COMAR 10.09.51 (.04)(B)(1)(b). Medical necessity does not include conditions for education, social, or activities for daily living. Two year loss and damage insurance is required for each new aid. *An asterisk identifies hearing aids that require preauthorization. Audiogram, audiologist report and the physician's clearance must be on file for all hearing aid requests and available upon request. All hearing aids and supplies are priced at acquisition cost to the provider.

V5030	BODY WORN, AIR CONDUCTION HEARING AID	B/R
V5040	BODY WORN, BONE CONDUCTION HEARING AID	B/R
V5050	MONAURAL, IN THE EAR	B/R
V5060	MONAURAL BEHIND THE EAR AIDS (SPECIFY)	B/R
V5080	GLASSES, BONE CONDUCTION	A/C*
V5100	BODY WORN, BILATERAL	B/R
V5120	BODY, BINAURAL	B/R
V5130	IN THE EAR, BINAURAL	B/R

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V5140	BEHIND THE EAR, BINAURAL (SPECIFY)	B/R
V5150	GLASSES, BINAURAL	A/C*
V5170	CROS, IN THE EAR	A/C
V5180	CROS, BEHIND THE EAR	A/C
V5190	CROS, GLASSES	A/C*
V5210	BICROS, IN THE EAR	A/C
V5220	BICROS, BEHIND THE EAR	A/C
V5230	BICROS, GLASSES	A/C*
V5242	ANALOG, MONAURAL, CIC (COMPLETELY IN THE EAR CANAL)	A/C*
V5243	ANALOG, MONAURAL, ITC (IN THE CANAL)	A/C*
V5244	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, CIC	A/C*
V5245	DIGITALLY PROGRAMMABLE ANALOG MONAURAL, ITC	A/C*
V5246	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, ITE (IN THE EAR)	A/C*
V5247	DIGITALLY PROGRAMMABLE ANALOG, MONAURAL, BTE (BEHIND THE EAR)	A/C
V5248	ANALOG, BINAURAL, CIC	A/C*
V5249	ANALOG, BINAURAL, ITC	A/C*
V5250	DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, CIC	A/C*
V5251	DIGITALLY PROGRAMMABLE ANALOG, BINAURAL, ITC	A/C*
V5252	DIGITALLY PROGRAMMABLE, BINAURAL, ITE	A/C

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PROCEDURE CODE	BRIEF DESCRIPTION	MAXIMUM FEE
V5253	DIGITALLY PROGRAMMABLE, BINAURAL, BTE	A/C
V5254	DIGITAL, MONAURAL, CIC	A/C*
V5255	DIGITAL, MONAURAL, ITC	A/C*
V5256	DIGITAL, MONAURAL, ITE	A/C
V5257	DIGITAL, MONAURAL, BTE	A/C
V5258	DIGITAL, BINAURAL, CIC	A/C*
V5259	DIGITAL, BINAURAL, ITC	A/C*
V5260	DIGITAL, BINAURAL, ITE	A/C
V5261	DIGITAL, BINAURAL, BTE	A/C
V5262	HEARING AID, DISPOSABLE, ANY TYPE, MONAURAL	N/C
V5263	HEARING AIDS, DISPOSABLE, ANY TYPE, BINAURAL	N/C
V5160	DISPENSING FEE+, BINAURAL	$175.00
V5200	DISPENSING FEE+, CROS	$106.00
V5240	DISPENSING FEE+, BICROS	$106.00
V5241	DISPENSING FEE +, MONAURAL	$106.00

+Services provided must be rendered directly to the recipient.. An orientation/counseling of the hearing aid user and family regarding use of the hearing aid, troubleshooting,hearing aid batteries and general issues related to hearing aid benefit and use must take place.

In addition, at least two of the following services must be provided under this fee:

- ***testing of hearing aid electroacoustically to check that it is performing according to manufacturer's specification***
- ***a listening check to ensure that the sound is without audible distortion and that the sound quality is acceptable***
- ***adjusting the hearing aid to meet the specification of the individual's hearing loss either through programming it with special software on a computer or through the potentiameter pods on the unit itself***
- ***functional behavioral test with the hearing aid user wearing the hearing aid(s) to get audiometric aided scores to confirm benefit of use of the instruments***

HEARING AID DISPENSERS PLEASE NOTE: If you do not directly dispense the aid(s) to the recipient you must use either code 92592 or 92593 (Hearing Aid Check). Do not use the dispensing fee code V5160, V5200, V5240, or V5241.

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V5264	EAR MOLD, NOT DISPOSABLE, *(LIMITATION = UP TO 2 PER MONAURAL/4 PER BINAURAL PER YEAR)*	$ 27.00
V5265	EAR MOLD/INSERT, DISPOSABLE,	N/C
V5266	REPLACEMENT BATTERY FOR USE IN HEARING DEVICE - MAXIMUM 48 PER YEAR FOR MONAURAL - MAXIMUM 96 PER YEAR FOR BINAURAL	$ 1.56
V5267	HEARING AID SUPPLIES /ACCESSORIES *(Medically necessary and effective services. Note: prophylactic ear protection - a copy of the signed Rx from the primary care doctor, and a documented history of tympanostomy tube must be on file.)*	A/C*
V5268	ASSISTIVE LISTENING DEVICE, TELEPHONE AMPLIFIER ANY TYPE	N/C
V5269	ASSISTIVE LISTENING DEVICE, ALERTING, ANY TYPE	N/C
V5270	ASSISTIVE LISTENING DEVICE, TELEVISION AMPLIFIER ANY TYPE	N/C
V5271	ASSISTIVE LISTENING DEVICE, TELEVISION CAPTION DECODER	N/C
V5272	ASSISTIVE LISTENING, DEVICE, TDD	N/C
V5273	ASSISTIVE LISTENING DEVICE, FOR USE WITH COCHLEAR IMPLANT	N/C
V5274	ASSISTIVE LEARNING DEVICE, NOT OTHERWISE SPECIFIED	N/C
V5275	EAR IMPRESSION, EACH	NCASP
V5014	REPAIR/MODIFICATION OF A HEARING AID ***(Extended warranty period for aid has expired. Note: Regulations stipulate that new aids be fully covered by a repair warranty and insured for loss or theft for a period of 2 years per hearing aid.)***	A/C

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X0103	HEARING AID INSURANCE/WARRANTY	A/C
	Maryland Medicaid covers new hearing aids if covered for two years for loss and repairs. Claim will be priced the actual acquisition cost for the service. A copy of the manufacturer's invoice with the recipient's name, serial number for the aid(s) and expiration date of the coverage must be maintained in records and available upon request. Because Maryland Medicaid stipulates that new hearing aids be insured for loss and repairs for a two year period, manufacturer processing and/or replacement fees are not coverable. Supplemental insurance for these costs may be coverable when appropriate.	
99002	HANDLING/CONVEYANCE SERVICE FOR DEVICES *(Manufacturer's Shipping And Handling Charge – manufacturer's invoice must be maintained in records and available upon request.. Please use this code when billing for this service. Do not bill under the hearing aid, accessory or repair charge.)*	A/C

NOTE: PREAUTHORIZATION OF SERVICE DOES NOT GUARANTEE PAYMENT. IT IS IMPORTANT THAT MARYLAND MEDICAID'S EVS SYSTEM 1-866-710-1447 or www.emdhealthchoice.org BE UTILIZED ON THE DATE OF SERVICE TO VERIFY RECIPIENT ELIGIBILITY.

DOCUMENTATION FOR REQUESTED SERVICES MUST DEMONSTRATE MEDICAL NECESSITY* AND DIRECTLY RELATE TO THE CHILD'S MEDICAL CONDITION. MEDICAL NECESSITY DOES NOT INCLUDE CONDITIONS FOR EDUCATION, SOCIAL, OR ACTIVITIES FOR DAILY LIVING.

*Medically necessary means that the service or benefit is directly related to diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition; consistent with current accepted standards of good medical practice; the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and not primarily for the convenience of the consumer, family or provider.

Itemize charges. (i.e. insurance, repair, shipping/handling and accessory/supply charges should be billed by using the assigned code for the service and the acquisition cost. Do not combine these charges with the hearing aid or repair charge.)

Spare/backup hearing aids, cochlear implant speech processors and the repair to spare/backup hearing aids and cochlear implant speech processors are a non-covered Medicaid service. Do not bill for these services.

Code 92620- evaluation of central auditory function (CAP testing) is not covered for educational or behavior planning. This service requires preauthorization, submit a copy of the medical referral and medical report for coverage consideration. Otherwise, contact the local school system or DDA for coverage.

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SERVICES THAT REMAIN THE RESPONSIBILITY OF THE MCO ARE:

1. ALL CODES BILLED BY PEDIATRICIANS, INTERNISTS, FAMILY PRACTITIONERS, AND NEUROLOGISTS OR OTHER PHYSICIANS TO DETERMINE WHETHER A CHILD HAS A NEED FOR OT, PT, ST OR AUDIOLOGICAL SERVICES REMAIN THE RESPONSIBILITY OF THE MCO AND MAY NOT BE BILLED FEE-FOR-SERVICE.

2. SERVICES PROVIDED BY ANY PHYSICIANS OR NURSE PRACTITIONERS TO IDENTIFY CHILDREN WHO NEED TO BE REFERRED FOR FURTHER EVALUATION, SUCH AS DEVELOPMENTAL SCREENS OR PURE TONE AUDIOLOGIC SCREENING TESTS ARE NOT BILLABLE TO THE MEDICAL ASSISTANCE PROGRAM AS THERAPY/AUDIOLOGY SERVICES. THESE REMAIN THE RESPONSIBILITY OF THE CHILD'S MCO AND NEED TO BE PROVIDED WITHIN THE MCO'S GUIDELINES. IN ADDITION, PAYMENT FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES, OTHER THAN HEARING AIDS AND HEARING AID SUPPLIES, REMAIN THE RESPONSIBILITY OF THE CHILD'S MCO.

3. NEWBORN HEARING SCREENS.

4 SERVICES THAT **REMAIN THE RESPONSIBILITY OF THE MCO** WHEN BILLED BY PHYSICIANS OR NURSE PRACTITIONERS INCLUDE THE FOLLOWING CODES **AND OTHERS** TYPICALLY BILLED BY PHYSICIANS **TO SCREEN PATIENTS IN NEED OF THERAPY OR AUDIOLOGY SERVICES:**

92551	AUDIOLOGIC SCREENING TEST
92552	PURE TONE AUDIOMENTRY
92567	TYMPANOMETRY
92568	ACOUSTIC REFLEX TESTING
96000-96120	CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS (NEUROCOGNITIVE, MENTAL STATUS, SPEECH TESTING)
96110	DEVELOPMENTAL TESTING, LIMITED
96111	DEVELOPMENTAL TESTING, EXTENDED

FEE FOR SERVICE (CLAIMS BILLED DIRECTLY TO MARYLAND MEDICAID):

SERVICES PROVIDED BY A MARYLAND MEDICAID ENROLLED AUDIOLOGIST WILL BE PAID FEE-FOR-SERVICE. (REFER TO THIS SCHEDULE FOR COVERABLE PROCEDURE CODES.) PREAUTHORIZATION OR A REFERRAL FROM THE MCO IS NOT NEEDED FOR EVALUATION AND TREATMENT BY A MARYLAND MEDICAID ENROLLED AUDIOLOGIST OR FOR HEARING AIDS FROM AN ENROLLED HEARING AID DISPENSER.

FOLLOW-UP EVALUATIONS FOR FAILED NEWBORN HEARING SCREENS SHOULD BE BILLED DIRECTLY TO MARYLAND MEDICAID.

UNDER MARYLAND MEDICAID, AN AUDIOLOGIST IS NOT CONSIDERED A PHYSICIAN EXTENDER. IT IS INAPPROPRIATE TO USE A PHYSICIAN ASSIGNED PROVIDER NUMBER TO BILL FOR SERVICES RENDERED BY AN AUDIOLOGIST. THE AUDIOLOGIST MUST BE ENROLLED WITH THE PROGRAM. THE ENROLLED AUDIOLOGIST MUST USE HIS/HER ASSIGNED PROVIDER NUMBER FOR PREAUTHORIZATION AND BILLING PURPOSES.

VISIT THE FOLLOWING WEBSITE TO REVIEW THE REGULATIONS FOR EPSDT - AUDIOLOGY SERVICES AND GENERAL MEDICAL ASSISTANCE PROVIDER PARTICIPATION CRITERIA:
www.dsd.state.md.us/comar

Select option #3; Choose select by title number; Select Title Number 10 - Department of Health and Mental Hygiene; Select Subtitle 09 - Medical Care Programs; Select regulation 10.09.51 - EPSDT: Audiology Services and 10.09.36 – General Medical Assistance Provider Participation Criteria.

VISIT THE FOLLOWING WEBSITE TO REVIEW ADDITIONAL PROVIDER INFORMATION:

www.dhmh.state.md.us/mma/providerinfo

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
AUDIOLOGY SERVICES

SECTION I - Patient Information

Medicaid Number |___|___|___|___|___|___|___|___|___|___|___|___|

Name_____ DOB_____ Sex_____ Telephone (____)_____
(Last) (First) (MI)

Address_____

SECTION II - Preauthorization General Information

Pay to Provider Number |___|___|___|___|___|___|___|___|___|

Name _____ Request Date _____

Address _____

Contact _____ Telephone (_____) _____

Provider's Signature _____

SECTION III - Additional Preauthorization Information

Prescribing Audiologist Provider Number |___|___|___|___|___|___|___|___|___|___|

Name _____ Telephone (____) _____

Address _____

SECTION IV - Preauthorization Line Item Information

DESCRIPTION OF SERVICE	PROCEDURE CODE	MOD	REQUESTED UNITS	AMOUNT	DATES OF SERVICE FROM	THRU	AUTHORIZED UNITS	AMOUNT
				$				
				$				
				$				
				$				
				$				
				$				

PREAUTHORIZATION NUMBER

|___|___|___|___|___|___|___|___|___|___|___|___|

SUBMIT TO: Office of Operations and Eligibility Services
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

DOCUMENT CONROL NUMBER
(STAMP HERE)

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
AUDIOLOGY SERVICES

SECTION V - Specific Program Preauthorization Information

Patient Location: Home___ Nursing Home ___ Hospital Inpatient___ Discharge Date _____

Address where equipment will be used (if different from Above): Period of time required:

_____ _____

_____ _____

_____

MFGR	MODEL/PRODUCT	SINGLE UNIT	AMT. PKG
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____
_____	_____	$_____	_____

Diagnosis and Present Physical Condition _____

_____

Prognosis _____

_____

Treatment Plan _____

_____

Expected Therapeutic Effect _____

_____

SECTION VI (DHMH USE ONLY)

_____Approved _____Denied

REASON (S) _____

_____

Medical Consultant's Signature _____ Date _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE(S): Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.
